

Meningococcal Vaccine: Promoting Awareness and Vaccinating Students

Recently, two pieces of legislation related to meningococcal disease and vaccination were enacted.

Chapter 228 of the Acts of 2004: An Act Relative to Meningitis Awareness - This statute promotes awareness of meningococcal disease and immunization. It requires the dissemination of information about the risks of meningococcal disease and about the availability, effectiveness and risks of meningitis vaccine in a variety of settings, including day care centers, schools and camps.

Chapter 229 of the Acts of 2004: An Act Requiring College Student Immunization Against Meningococcal Disease - This statute requires meningococcal vaccination for students at those secondary and postsecondary schools, which provide or license housing. Beginning in August 2005, all entering students, including full and part-time graduate and undergraduate students, will need to receive meningococcal vaccine prior to the beginning of classes or decline vaccine. This applies regardless of whether the student resides in campus housing or not.

Students may sign a waiver that reviews the dangers of meningococcal disease and indicates that the vaccination has been declined. To qualify for this exemption students (or if the student is under 18 years of age a parent or legal guardian) must review and sign the Massachusetts Department of Public Health waiver form stating that they have read and understood the information related to the risks of meningococcal disease and are foregoing vaccination.

The Department is developing appropriate educational materials, meeting with stakeholders and drafting regulations to define these two new requirements further.

The currently available vaccine provides protection against four serogroups of *Neisseria meningitidis* (A, C, Y and W-135). These four serogroups account for approximately two-thirds of the cases that occur in the US each year. Most of the remaining one-third of the cases are caused by serogroup B, which is not represented in the vaccine. Protection through immunization with the meningococcal polysaccharide vaccine is not lifelong; it lasts about 3 to 5 years in healthy adults (some people may be protected longer). If you have questions about these new requirements, please contact the Immunization Program at (617) 983-6800.

Massachusetts Infertility Prevention Project (IPP)

The Massachusetts IPP is a chlamydia screening and data collection project that is being conducted in a variety of clinical settings. The primary purpose is the prevention of infertility through appropriate chlamydia screening and treatment of sexually active women aged 18-24 years.

As many as 85% of women with chlamydial infection are asymptomatic. Undiagnosed chlamydial infection can lead to reproductive health complications, including pelvic inflammatory disease, ectopic pregnancy, and infertility. Demographic data is being collected to inform prevention efforts and screening recommendations.

The project is being conducted at seventeen family planning sites, thirteen categorical STD clinics, eighteen school-based health centers, four jails and six youth detention centers. Below is a description of the positivity rates by site type for 2003.

Site Type	Total Tested	Number Positive	Percent Positive
Family Planning (17)	9,959	413	4.2%
STD Clinics (13)	6,415	447	7.0%
School-Based Health Centers (18)	895	83	9.3%
Jails (4)	3,259	172	5.3%
Youth Detention (6)	2,253	120	5.3%
Drop In and Other Clinics	108	10	9.3%

¹Other clinics include a homeless shelter, an AIDS service organization, a pediatric medical group, a runaway clinic and a teen health center located in a primary care setting.

In 2005, a formal review of results by site will be conducted. This review will inform decision-making regarding provision of services to women with the highest risk of chlamydial infection.

For additional information on the IPP and chlamydia screening, please contact Bill Dumas, RN, at Bill.Dumas@state.ma.us, 617-983-6950.

Inside

Epidemiology	2
Immunization	3
HIV/AIDS	
Surveillance	5
Refugee Health	7
Save the Dates	3
STD	6
TB	8
You be the epi	4

Epidemiology

Hepatitis A: The Outbreak Continues

Reducing the risk of exposure to hepatitis A virus (HAV) for people in high-risk populations remains a priority of the Massachusetts Department of Public Health (MDPH). Reported cases of hepatitis A in Massachusetts this year are at a much higher level than previous years. From January 1 through November 30 of 2004, 927 cases of hepatitis A were reported to MDPH, as compared to 259 in all of 2003 and 150 in all of 2002. Surveillance data reveal that many cases share certain characteristics including, unemployment (40%), substance abuse (30%), coinfection with hepatitis C (22%), homelessness (18%), and recent or current incarceration (12%). Approximately 65% of the cases have at least one of these risk factors

The reasons for the increase in hepatitis A are not completely clear. Nationwide, hepatitis A rates have historically fluctuated over time with periodic increases in approximately 10-year cycles. For most of the past decade, the western United States has had the highest incidence of hepatitis A.

MDPH has promoted HAV vaccination and enhanced collaboration and partnership at the local level to conduct vaccination clinics for high-risk groups. HAV vaccine is available to provide vaccination for high-risk populations. This fall, MDPH sponsored seven regional forums to assist local boards of health and community-based organizations in their efforts to provide HAV vaccine for front-line response at jails, drug treatment programs and homeless shelters. These regional forums were created in response to feedback generated from earlier statewide hepatitis A summits meetings held in March and July 2004.

In addition to promoting vaccination, educational efforts have also been increased. MDPH has a designated hepatitis A web site at <http://www.mass.gov/dph/cdc/epii/hepatitis/hepa.htm>. This page includes fact sheets in various languages, information on vaccination and immune globulin, and a variety of hand washing educational materials. Materials have also been developed for at-risk populations encouraging hepatitis A vaccination and good personal hygiene. The Massachusetts Hepatitis Information Line (1-888-443-4372) can answer questions about hepatitis A and its prevention. MDPH regional health educators are available for on-site education and to distribute educational materials to agencies and communities. To contact your regional health educator or to order educational materials, call the Division of Epidemiology and Immunization at: 617-983-6800.



Fourth Annual Training on Infectious Disease Surveillance, Reporting and Control: What is it all About?

The Massachusetts Health Officers Association (MHOA) and the Massachusetts Association of Public Health Nursing (MAPHN), in conjunction with the Massachusetts Department of Public Health (MDPH) Bureau of Communicable Disease Control, Division of Epidemiology and Immunization, will present the 4th annual **Infectious Disease Surveillance, Reporting, and Control: What is it all About?** The training program was developed to improve the capacity of local boards of health to respond to infectious disease cases in their jurisdiction. This year's new material includes: updates on bioterrorism and emergency preparedness, changes to chickenpox reporting, and an interactive exercise on hepatitis A and setting up an IG clinic. Anyone who is responsible for communicable disease surveillance and control is encouraged to attend.

The following dates still have openings:

April 6, 2005 – Tyngsborough

April 13, 2005 – West Bridgewater

For more information, please contact Ruth-Ellen Sandler at (800) 214-6021 and enter the access code "00" or send email to resandler@mhoa.com.

..... The Legal Nuts and Bolts of Isolation and Quarantine

This training program is being offered a second time due to high demand. The goal is to prepare participants to respond to infectious disease emergencies by understanding, implementing and enforcing isolation and quarantine. The program explains the model legal documents presented in the isolation and quarantine satellite broadcast on March 30, 2004. Each training begins on site at 8:30 AM for registration. The training runs from 9:00 AM to 12:30 PM. The remaining training dates are:

Region 1 – Feb. 1, 2005
Berkshire Community College
1350 West Street
Pittsfield, MA
Susan B. Anthony Bldg. - A
Room G-10 on basement level

Region 2 – Feb. 8, 2004
Central Regional Office
180 Beaman Street
West Boylston, MA
Barr Conference Room

Online registration is available at <http://ma.train.org>. (There is no "www" in the address.) You will need to register as a TRAIN-Massachusetts user (if you have not already done so) before you can register for the program. Registration on TRAIN-Massachusetts is free, confidential and easy. If you are unable to register online, please contact Cathy McKenna at (617) 983-6856 for alternative registration arrangements.

Help Is On The Way! New State Immunization Tracking and Vaccine Management System

The shortage of flu vaccine this season underscores the challenges health care providers face in managing immunization records and vaccine. The need to report flu vaccine, keep track of vaccine supply during a dynamic situation and identify populations at risk for influenza challenges even the best prepared practices. Help is on the way! The Massachusetts Department of Public Health is developing a new immunization tracking and vaccine management system. The Massachusetts Immunization Information System (MIIS) is expected to pilot test in the spring of 2005. Here are just some of the features of this new web-based system:

- Track all immunizations given to children and adults at the dose and lot level
- Automatically project initial and next dose dates for each vaccine type based on the recommended childhood immunization schedule (CDC-ACIP)
- Electronic ordering of vaccines. (No more bubble sheets!)
- Automatic electronic receipt for vaccines ordered and loading of lot numbers into your databases
- Identify and generate lists and reminders for patients at risk for flu and other diseases
- Automatically make and send vaccine usage information
- Vaccine recall both for manufacturer and cold chain violations and reset of immunization status for affected patients
- Automatic inclusion of immunization history, status and immunity information on school reports
- Schools can look up a student's immunization record
- You only need have access to the internet to use it
- The MIIS is being provided for free

The MIIS will also provide sites with birth hepatitis B vaccination information. The system also has the capability to upload patient electronic record information from sites. Sites that use the system will not have to enter historical information or use two systems to record immunization information. Sites can use the system for both pediatric and adult immunization tracking and ordering. Parents and guardians will have the option to not have a record included in the system.

The Massachusetts system was acquired from the State of Wisconsin. Six other states are using or preparing to use the same base system. The MIIS is being modified to meet requirements specific to Massachusetts.

As the MIIS proceeds through a pilot test in the spring of 2005, more information about obtaining the system, training and support will be provided. For more information about the MIIS now, please contact:

Dennis Michaud, M.Ed., Director of Provider Relations
Massachusetts Immunization Information System
(617) 983-6838 or dennis.michaud@state.ma.us

Pneumococcal Conjugate Vaccine (PCV7) Shortage Resolved - Reinstatement of Fourth Dose

In September 2004, pneumococcal conjugate vaccine (PCV7) production increased, meeting the national demand allowing the routine 4-dose schedule (an increase from the 3-dose schedule in place since July 2004).

With vaccine production issues now resolved, the Centers for Disease Control and Prevention (CDC), in consultation with the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), recommends that providers resume administration of the vaccine according to the routine schedule. (CDC.MMWR 2004;53:851-852.) [URL:<http://www.cdc.gov/mmwrPDF/sk/mm5336.pdf>]

Prioritization of Groups for Catch-up

Groups should be prioritized for catch-up with PCV7 vaccine in the following order:

1. Any high-risk children* < 5 years of age with < 4 doses.
2. Healthy children < 24 months of age who have not received any doses and healthy children < 12 months of age who have received < 3 doses.
3. Healthy children 12-23 months of age who have received < 3 doses.

* High-risk children include those with sickle cell disease, asplenia, chronic heart or lung diseases, diabetes, cerebrospinal fluid leak, cochlear implant, human immunodeficiency virus infection or another immunocompromising condition, and American Indian or Alaska Native children in areas with demonstrated risk for invasive pneumococcal disease more than twice the national average (i.e., Alaska, Arizona, New Mexico, and Navajo populations in Colorado and Utah).

Any questions relative to catch-up immunization schedules, disease reporting and vaccine ordering can be directed to the Massachusetts Department of Public Health Immunization Program at (617) 983-6800 or (888) 658-2850. The latest PCV7 advisory, dated Sept. 17, 2004, can also be found online at: http://www.mass.gov/dph/cdc/epii/imm/pcv7_shortage.htm

Case

A 32-year-old man presents to an urgent care clinic for a nonpruritic rash and malaise that developed two days ago. His temperature is 37.5° C. He has no other complaints, is not taking any medication and has no significant past medical history.

Before you proceed to the physical examination, what other information would be important to obtain?

The clinician should conduct a complete sexual history. The symptoms described by the patient are consistent with secondary syphilis. It's important to obtain information on his HIV infection status, the gender and number of sexual partners, the nature of the relationships (steady and casual partners), if partners have other partners, types of sexual behaviors, sex partner meeting venues, condom use, and HIV infection status of partners.

The sexual history revealed that, in the past three months, the patient engaged in receptive and insertive oral sex with multiple male sexual partners he met through the Internet. He never used condoms. He never engages in anal intercourse. He has one steady male partner. Both he and his steady partner tested negative for HIV six months ago. He is unaware of the HIV status of his casual partners. He never has sex with women.

The physical examination shows a maculopapular skin eruption primarily on his trunk and arms, with lesions on the palms and soles. Some white patches are visible on his tongue, and enlarged lymph nodes are palpable bilaterally in his neck. The rest of the examination, including the anogenital area, is normal. Men who have sex with men (MSM) are at risk for syphilis.

In Massachusetts, the number of cases of primary and secondary (P&S) syphilis increased from 105 in 2001 to 257 in 2003, with higher rates occurring in men.

Whereas less than 1% of all cases of P&S syphilis in 1990 occurred among MSM, more than 75% of the cases in 2003 were detected in MSM. In addition, a large proportion of men with infectious syphilis (P&S and early latent) were HIV co-infected.

Similar increases in infectious syphilis among MSM has also been reported in other areas of the United States, such as Southern California, San Francisco, Houston, Seattle, and New York City. The CDC estimates that over 40% of all cases of P&S syphilis in 2002 in the United States were among MSM.

The Division of STD Prevention, in collaboration with other public health and community partners, has engaged in multiple pre-

vention control and control interventions in the last two years in an effort to reduce the incidence of infectious syphilis among MSM. In 2004, the number of reported cases among MSM has decreased by more than 50%.

Transmission of syphilis

Treponema pallidum, the organism causing the syphilis, enters the body via skin and mucous membranes through macroscopic and microscopic abrasions. A local lesion (the chancre of primary syphilis) appears at the site of inoculation, which could be anywhere on the body (not just the genital area). The chancre, which is typically painless, develops 10 to 90 days after inoculation. It may be overlooked by the patient. It can heal without treatment after 1 to 6 weeks. The secondary lesions of syphilis generally appear 3 to 6 weeks after the appearance of the chancre. It's important to remember that syphilis can be transmitted through oral as well as through vaginal and anal sex.

Diagnostic testing

Serologic tests for syphilis should be performed. A nontreponemal test (such as the RPR) should be done first. If positive, it should be confirmed by a treponemal test. Both these tests are virtually always positive during secondary syphilis. A "prozone reaction" may occur if the antibody titer is very high, resulting in a false negative nontreponemal test. If clinical suspicion of secondary syphilis is high, the clinician should request that the laboratory dilute the serum to at least a 1/16 dilution to rule out the prozone effect. This patient should also be tested for other STDs and be offered counseling and testing for HIV infection.

Treatment

The Massachusetts Division of STD Prevention recommends that two doses of benzathine penicillin G, 2.4 million units, IM, 1 week apart (total 4.8 million units), be administered for the treatment of secondary syphilis.

Reporting

Clinicians should promptly report all cases of syphilis to the Division of STD Prevention.

What are about the sexual partner?

The Division of STD Prevention (DSTDP) conducts partner services routinely for designated public health "priority cases", which include all reported cases of infectious syphilis (primary, secondary and early latent). This means the DSTDP will attempt to contact all "priority cases" for an interview. Highly trained staff, called disease intervention specialists (DIS), conduct these functions.

The DSTDP always contacts the health care provider before communicating with the patient to confirm diagnosis and inform of the intent of delivering partner services. For STD

continued on page five

HIV/AIDS Surveillance

HIV/AIDS Morbidity and Risk Behavior Surveillance

The Massachusetts Department of Public Health HIV/AIDS Surveillance Program (MHASP) has received funding from Centers for Disease Control and Prevention (CDC) for a supplemental surveillance project involving chart abstraction and patient interviews. The purpose of this project is to gain greater understanding of the clinical course of HIV infection and factors related to disease events. Behavioral information (from interviews) and clinical information (from medical records) will be used to determine the interaction between behavior and disease progression. This knowledge will serve to enhance prevention strategies.

This project will lead to the development of a supplemental HIV/AIDS surveillance system, which will produce population-based estimates of the characteristics of persons with HIV infection and the care they receive. By using probability sampling, estimates will be developed that represent populations in care and diagnosed with HIV infection. Measurable outcomes of the program will be in alignment with the following CDC goal: "Strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions, and evaluate prevention programs."

Of particular interest will be how patient adherence to prescribed antiretroviral regimens affects disease progression, virologic response to antiretroviral therapy, CD4 counts and incidence of opportunistic infections. Barriers to adherence cited by patients (e.g., side effects, pill burden) will be ascertained. Additionally, medical record abstraction will provide key information about clinical events, such as immunizations and screening for tuberculosis infection and sexually transmitted diseases, CD4 counts, AIDS diagnosis, and receipt of prophylactic and antiretroviral medications.

HIV/AIDS Epidemiologic Profile

Previous editions of the HIV/AIDS Epidemiologic Profile have been released annually as a comprehensive document with full-length chapter summaries. This year, the Epidemiologic Profile will be released quarterly with a revised fact sheet format. The goal for the revised format and release plan is to make the document more accessible and allow for more timely access to data. Each quarterly release will contain a series of fact sheets with supporting appendices of relevant data tables and technical notes. The standard appendices such as the glossary and list of acronyms (which pertain to all releases of the profile) will be included with the first quarterly release scheduled for October of 2004. For a full description of the content and timeline for the quarterly release schedule please see the HIV/AIDS Bureau website at www.mass.gov/dph/aids



You Be the Epi

Continued from page four

"priority cases", it is helpful if clinicians inform patients that a DIS from the DSTDP will be contacting them to discuss sexual partners. Patients will be contacted directly by the DIS only if all attempts to reach the health care provider fail. The interview for partner elicitation is always voluntary.

For case investigation and surveillance of reportable diseases, clinicians and health care institutions should know that access by the DSTDP staff to hospital, clinic and laboratory records is specifically authorized under the Massachusetts General Laws (Chapter 111, Sections 53 and 119, Chapter 111D, Section 6). Access to medical records is also allowed under the federal Health Insurance Portability and Accountability Act (HIPAA) regulations (45 CFR 164.512b). Those regulations state that a covered entity is allowed to disclose protected information to a public health authority (without written authorization of the individual or opportunity of the individual to agree or object) when it is used for the purpose of preventing or controlling disease, injury or disability. The DIS may need to review records to confirm the patient diagnosis and gather relevant information. Once done, partner services can be offered.

For secondary syphilis, DIS attempt to elicit information about all sexual partners the infected person has had in the six months prior to diagnosis. These partners should be evaluated (examined and tested for syphilis). Partners who have had contact with the patient within 90 days should also receive prophylactic treatment (one dose of benzathine penicillin G, 2.4 million units, IM) regardless of serologic results (partners may not yet have seroconverted).

For further information on partner services, contact Bill Dumas, RN, at (617) 983-6950.

STD Clinic Update in Massachusetts

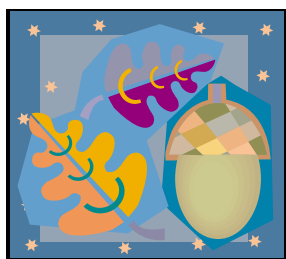
Massachusetts has experienced a decrease in categorical STD clinic services since 1937, when there were twenty-three hospital-based STD clinics. Currently, there are only eight state-funded STD clinics in Massachusetts, down from thirteen in 2001. These clinics are distributed around the Commonwealth and provide comprehensive STD services and HIV testing to approximately 15 – 20,000 patients per year. Approximately 14% of STDs reported to the MDPH are diagnosed in these clinics. A large proportion of the people seen in the clinics are uninsured and have no regular source of care or chose not to be seen in the private sector for care

In 2004, MDPH provided support to nine categorical STD clinic sites in the following communities: Boston (2), Chelsea, Fall River, Springfield, Worcester, Lowell, Brockton and Pittsfield. Four clinics are in hospitals, one clinic is at a Planned Parenthood facility and four are located at community health centers. There also is a clinic located at the Awaiting Trial Unit at the Massachusetts Correctional Institute at Framingham, the state's women's prison and a major awaiting trial facility for women. These clinics are located in areas that had high STD morbidity rates in the past. The STD clinics provide complete STD diagnostic, treatment and prevention services.

In addition to STD care and confidential HIV testing, all STD clinics provide referrals for primary care, family planning and substance abuse. The referral may occur in-house, to the patient's own primary care physician or to an outside facility or agency.

All of the STD clinics operate on a walk-in basis and vary in hours of operation. The larger sites see patients at ten clinic sessions per week, whereas the smaller sites see patients at two clinic sessions per week. All patients are seen regardless of their ability to pay. All STD clinics are expected to obtain third party reimbursement if a patient has coverage and is willing to use it. The clinics continue to see more male patients (65%). To the right is a summary of patient visits and STDs diagnosed by clinic site for January – June 2004.

A list of STD clinics and their of operation can be found at: <http://www.mass.gov/dph/cdc/std/services/clinicsched.htm>.



**Summary of STD Clinic Patients
January - June 2004**

<i>STD Clinic</i>	<i>Total Visits</i>	<i>Female Visits</i>	<i>Male Visits</i>	<i>Chlamydia Cases</i>	<i>Gonorrhea Cases</i>	<i>Syphilis Cases</i>
<i>Baystate Health Center</i>	765	270	495	60	18	5
<i>Berkshire Medical Center</i>	313	127	185	15	7	1
<i>Boston Medical Center</i>	1606	440	1166	90	30	15
<i>Brockton Hospital</i>	1142	421	721	51	10	17
<i>Lowell Community Health Center</i>	479	129	350	43	7	5
<i>Massachusetts General Hospital (Including Chelsea Health Center)</i>	4312	1279	3033	82	135	25
<i>Planned Parenthood of Worcester</i>	480	240	340	40	6	7
Total	9097	2906	6190	381	113	75

Clinician Toolkit on MSM Sexual Healthcare - Coming Soon!

A clinician's tool kit is being prepared for health care providers to assist in providing health care to men-who-have-sex-with-men (MSM). It is hoped that this toolkit will be a useful reference for clinicians providing all levels of care. Developed jointly by the Division of STD Prevention and Fenway Community Health, it will be available on-line and as hard copy in January, 2005. The toolkit includes materials that will assist clinicians in understanding sexual orientation, creating a MSM-friendly office, and conducting STD screening and treatment for MSM, and supporting STD prevention efforts.

Gay, lesbian, bisexual and transgender individuals represent a significant proportion of persons living in Massachusetts. At least 3% of men report sexual activity with other men. MSM are likely to seek care in many medical practices, whether or not recognized. The toolkit can facilitate provision of more effective care to MSM.

For further information, please contact David Novak, LICSW, David.Novak@state.ma.us, 617-983-6956.

Refugee and Immigrant Health

Refugee Admissions: 2004-2005

2004 Admissions: With the close of the 2004 federal fiscal year (FFY04) on September 30, 2004, the U.S. refugee admissions program appears to have returned to pre-September 11, 2001 levels of arrivals. There were 52,868 refugees resettled across the country during FFY04, an 85% increase over the previous year. Over one-fifth of these refugees arrived in September, the last month of the fiscal year.

Africa was the region from which the largest number of refugees were resettled. According to the U.S. Department of State, this reflects the reality that Somali Bantus and certain Liberians could not be safely repatriated, nor could they be integrated into the countries in which they had sought refuge. Of the over 29,000 African refugees admitted, 13,331 were from Somalia and 7,140 were from Liberia. African refugees were from twenty-one countries of origin.

Another large population for which resettlement began in FFY04 is the 15,000 Hmong from Wat Tham Krabok, Thailand. Most of these refugees had spent many years at this temple complex. Following the first arrivals on June 21, 2004, over 6,000 Hmong were admitted by the end of September. Most Hmong were reunited with family members in California, Minnesota, North Carolina and Wisconsin. The remainder of the population is expected to arrive during FFY05.

Resettlement from the former Soviet Union continued, with 8,765 individuals arriving from fifteen countries of the Newly Independent States. Nearly 500 refugees from countries of the former Yugoslavia were also admitted.

Among refugees from the Americas and Caribbean region, most were from Cuba, with nearly 3,000 arriving during the year. The only other population from this region with significant arrivals was Colombian.

2005 Admissions: President George W. Bush signed the Presidential Determination on FFY 2005 Refugee Admissions to the United States on October 1, 2004. Again, a total of 70,000 admissions were authorized, with 20,000 in the "unallocated reserve" category.

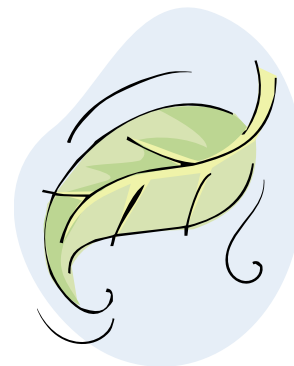
The U.S. will continue to consider individuals referred by the United Nations High Commission for Refugees (UNHCR), U.S. embassies or non-governmental organizations for resettlement. Group referrals are used for specific groups identified by the U.S. government in consultation with UNHCR, non-governmental organizations and other experts. In-country processing will continue for certain groups in the former Soviet Union, Cuba and Vietnam. Among the groups outside their country of origin that have been identified for resettlement are Meskhetian Turks in Russia; Hmong at Wat Tham Krabok in Thailand; Iranian religious minorities, primarily in Austria; Vietnamese in the

Philippines; Somali Benadir in Kenya; Burundians in Tanzania; Somali groups in Uganda; and Liberian groups in Ghana and Guinea. Other groups may be designated during the year.

In addition to individuals and priority groups, the U.S. will consider for interview refugees from fourteen designated countries who are spouses, unmarried children under 21 or parents of refugees or asylees in the U.S. The country list has been expanded to include Burma, Burundi, Congo, Democratic Republic of Congo, Colombia, Cuba, Ethiopia, Eritrea, Haiti, Iran, Liberia, Rwanda, Somali and Sudan.

The table summarizes refugee admissions by region for FFY03-05 – actual arrivals for FFY03 and FFY04, and allocations for FFY04 and FFY05.

Refugee Admissions: 2004-2005				
<i>Region</i>	<i>Total Arrivals in FFY03</i>	<i>FFY04 Regional Ceiling</i>	<i>Total Arrivals in FFY04</i>	<i>FFY05 Regional Ceiling</i>
<i>Africa</i>	7,737	30,000	29,125	20,000
<i>East Asia</i>	1,567	8,500	4,489	13,000
<i>Europe and Central Asia</i>	9,881	13,000	9,254	9,500
<i>Latin America/Caribbean</i>	321	3,600	3,556	5,000
<i>Middle East/South Asia</i>	3,764	3,000	2,854	2,500
<i>Unallocated Reserve</i>	-	11,900	-	20,000
Total	23,270	70,000	52,868	70,000



TB

Working with High School Students to Develop a Visual Tuberculosis Educational Aide

Most people living in Massachusetts obtain their health information through print materials; however, a significant portion of our population has low literacy skills or is literate in a language other than English. For these populations, printed materials or materials that are English-language specific, may be of limited use.

The Division of Tuberculosis Prevention and Control faced a challenge – how to explain the importance of adherence to treatment for latent tuberculosis infection (LTBI) using an approach that would overcome language barriers and address low-literate audiences. A visual educational aide, a story in pictures to be used in conjunction with a dialogue between the TB clinic health care worker and the patient would help address that challenge. Because the visual aide would contain no language, graphics were of key importance: they had to deliver a clear message and they had to appeal to a wide audience. The TB Division tapped an enthusiastic and innovative resource – high school commercial art students.

In collaboration with Framingham's Keefe Technical School instructor Mr. Kurt Schneider and his commercial art students, the TB Division developed *TB Infection: Taking the Right Path*. Before production on the *TB Infection: Taking the Right Path* began, a TB Division health educator met with Mr. Schneider and his students to explain the project and present a basic TB in-service that described TB transmission and pathogenesis, and the difference between latent TB infection and TB disease. The students took it from there. The desktop-sized bi-fold that they developed depicts a visual storyline: a patient, in contact with a contagious TB case, becomes TB infected (significant tuberculin skin test and normal chest x-ray), and is offered medication for latent TB infection. At this point the visual path diverges into two storyline outcomes. The patient taking one path discards the TB medications, becomes ill with TB disease and infects friends and family. The same patient, taking *The Right Path*, is adherent with his TB medications, continues to have a normal chest x-ray and enjoys a healthy life. To appeal to both adult and youth audiences, two versions of *The Right Path* were produced. As an added benefit, inventive students produced activities pages (connect-the-dots, word search, crossword puzzles, find the way to TB clinic) for children of varying ages. The materials will soon be available in TB clinic waiting rooms.

The Division of Tuberculosis Prevention and Control wishes to thank Mr. Kurt Schneider and the Commercial Art students of Keefe Technical School for their fine work and dedication in producing *TB Infection: Taking the Right Path*, an alternative approach to health education.



New Staff Member

The Division of Tuberculosis Prevention and Control is pleased to welcome Shuma R. Panse to the staff. Shuma is a CDC fellow participating in the Public Health Prevention Service (PHPS) fellowship program. Over the next two years, she will be conducting an assessment of statewide TB clinical service delivery and, subsequently, developing recommendations for a new strategic plan for the delivery of TB clinical services in Massachusetts. Shuma holds an MPH from Tulane University and a BA from Barnard College. She brings a wealth of public health knowledge and expertise to the Division and we look forward to her contribution to the TB elimination effort in the Commonwealth.

Nursing Spotlight

Ruth Jones, one of two Quincy Health Department nurses, is highlighted in this newsletter.

Ruth graduated from the Quincy Hospital School of Nursing, and recently, was awarded a BSN from Curry College. She is a past treasurer of the Southeast Chapter of the Massachusetts Association of Public Health Nurses.

Public health nursing was Ruth's goal. Her desire was met nearly five years ago when she was hired by the Quincy Health Department. Previously, she had been hospital-based and functioned in a private practice for ten years as a CDE (Certified Diabetes Educator). Her teaching skills and contact with the public, which she describes as "the best parts of her job", are evidenced by her broad scope of public health knowledge and her daily work with diverse populations.

In addition to her "traditional" public health nursing responsibilities, Ruth currently provides supervision and mentoring for Boston University School of Public Health masters students. In addition, she is currently developing partnerships with local
continued on page nine

Save the Dates

4th Annual Training on Infectious Disease Surveillance, Reporting & Control: What Is It All About?

Target audience: New local health department personnel and anyone responsible for communicable disease reporting. Persons who have attended this training in the past are welcome to attend again. All trainings run from 8:30 AM to 4:00 PM. Contact Ruth-Ellen Sandler at (800) 214-6021, pin #00 or by email: resandler@mhoa.com

Training dates and locations:

April 6, 2005: Tyngsborough

April 13, 2005: West Bridgewater



Nursing Spotlight *continued from page eight*

colleges to provide public health internships. When tattooing was legalized in Massachusetts, all tattoo artists were mandated to take anatomy and physiology or a "skin course approved by the local Health Department". There were, however, no courses in place. Ruth worked with the Boston University School of Medicine, Department of Dermatology to help develop a program that she now teaches to any tattoo artist in need of licensure statewide.

As Ruth sees it, the biggest challenge in her position is overcoming language barriers, especially over the phone. For example, 23% of the community is from Asia. Ruth does a superb job as a nurse case manager with her tuberculosis caseload and has, with the help of a Chinese Outreach Educator, been able to improve communication during home visits. Ruth's passion for teaching and her commitment to public health make her an essential and respected component of public health in her community.

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<http://www.mass.gov/dph/cdc/update/comnews.htm>

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